



House of Representatives

General Assembly

File No. 345

January Session, 2017

Substitute Senate Bill No. 925

House of Representatives, March 30, 2017

The House Committee on Insurance and Real Estate reported through REP. SCANLON of the 98th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING THE COST OF PRESCRIPTION DRUGS AND VALUE-BASED INSURANCE DESIGN.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

- 1 Section 1. (NEW) (*Effective January 1, 2018*) For the purposes of this
- 2 section and sections 2 to 8, inclusive, of this act, unless a different
- 3 meaning is specifically prescribed:
- 4 (1) "Commissioner" means the Insurance Commissioner;
- 5 (2) "Drug" has the same meaning as provided in section 21a-92 of
- 6 the general statutes;
- 7 (3) "Health care provider" or "provider" has the same meaning as
- 8 provided in section 38a-478 of the general statutes;
- 9 (4) "Health care services" has the same meaning as provided in
- 10 section 38a-478 of the general statutes;

11 (5) "Health carrier" or "carrier" means any insurer, health care
12 center, fraternal benefit society, hospital service corporation, medical
13 service corporation or other entity that delivers, issues for delivery,
14 renews, amends or continues a health insurance policy in this state;

15 (6) "Health insurance policy" means an individual or group health
16 insurance policy in this state that provides coverage of the type
17 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of
18 the general statutes;

19 (7) "Manufacturer" has the same meaning as provided in section
20 21a-70 of the general statutes;

21 (8) "Net drug cost" means the cost of a brand name prescription
22 drug or generic drug net all discounts and rebates for such drug;

23 (9) "Pharmacy benefits manager" or "manager" has the same
24 meaning as provided in section 38a-479aaa of the general statutes;

25 (10) "Value-based insurance design" means any material term in a
26 health insurance policy that is designed to increase the quality of
27 covered benefits or health care services while reducing the cost of such
28 policy, benefits or health care services;

29 (11) "Wholesale acquisition cost" means the cost of a brand name
30 prescription drug or generic drug, excluding any discount, rebate or
31 other price reduction, as listed in the most recent edition of the catalog
32 or price list a manufacturer provides to wholesalers or distributors;
33 and

34 (12) "Wholesaler" or "distributor" has the same meaning as provided
35 in section 21a-70 of the general statutes.

36 Sec. 2. (NEW) (*Effective January 1, 2018*) (a) On and after January 1,
37 2018, each health carrier delivering, issuing for delivery, renewing,
38 amending or continuing any health insurance policy in this state
39 providing coverage of the type specified in subdivision (1), (2), (4),
40 (11), (12) or (16) of section 38a-469 of the general statutes that provides

41 coverage for prescription drugs shall offer for sale a version of each
42 such policy that incorporates value-based insurance design for
43 prescription drug benefits.

44 (b) A health carrier, in developing such value-based insurance
45 design, shall consider services and benefits that are: (1) Provided on an
46 outpatient basis; (2) medically beneficial and cost-effective; (3) likely to
47 prevent hospitalization or use of emergency services; (4) preventive;
48 and (5) at low risk of abuse or fraud.

49 Sec. 3. (NEW) (*Effective January 1, 2018*) On and after January 1, 2018,
50 each group health insurance policy providing coverage of the type
51 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of
52 the general statutes delivered, issued for delivery, renewed, amended
53 or continued in this state, that provides coverage for prescription
54 drugs and requires a percentage coinsurance payment or deductible
55 for a prescription drug, shall calculate the coinsurance payment or
56 deductible based on (1) the actual net drug cost of such drug, or (2) an
57 estimate of the net cost of such drug based on recent historical data.

58 Sec. 4. (NEW) (*Effective January 1, 2018*) On and after January 1, 2018,
59 any contract that is entered into, renewed or amended in this state
60 between a health carrier and a health care provider that requires the
61 carrier to reimburse the provider for the cost of a prescription drug, the
62 cost of administering a prescription drug or any overhead or handling
63 cost concerning a prescription drug: (1) Shall require that the carrier
64 separately reimburse the provider for (A) the cost of the drug, (B) the
65 cost of administering the drug, and (C) any overhead or handling cost
66 incurred in connection with the drug; and (2) shall not set the amount
67 of any reimbursement of the type specified in subparagraph (B) or (C)
68 of subdivision (1) of this section at a fixed percentage of the cost of the
69 drug.

70 Sec. 5. (NEW) (*Effective January 1, 2018*) (a) Each manufacturer shall
71 send written notice to the commissioner if the manufacturer decides to:
72 (1) Sell or distribute in this state (A) any brand name prescription drug
73 that has an initial annual aggregate wholesale acquisition cost that is

74 equal to or greater than thirty thousand dollars, or (B) any generic
75 drug that has an initial annual aggregate wholesale acquisition cost
76 that is equal to or greater than three thousand dollars; or (2) increase
77 the annual aggregate wholesale acquisition cost of (A) any brand name
78 prescription drug sold or distributed in this state by more than ten per
79 cent or ten thousand dollars, whichever is lower, or (B) any generic
80 drug sold or distributed in this state by more than twenty-five per cent
81 or three hundred dollars, whichever is lower.

82 (b) The manufacturer shall send the notice required under
83 subsection (a) of this section to the commissioner not later than sixty
84 days after the release date of the prescription drug or the effective date
85 of the price increase, whichever is applicable. The notice shall be on a
86 form prescribed by the commissioner and contain the following:

87 (1) With respect to each factor involved in the manufacturer's
88 calculation of the wholesale acquisition cost:

89 (A) A description of the factor;

90 (B) The percentage of the total wholesale acquisition cost
91 attributable to such factor;

92 (C) An explanation of the role such factor played in the
93 manufacturer's calculation;

94 (2) A description of all efforts made to reduce the cost of the drug to
95 consumers;

96 (3) Any increases in the wholesale acquisition cost of the drug
97 during the previous five years;

98 (4) Any other information the commissioner may require; and

99 (5) A statement from the manufacturer certifying that the
100 information it has disclosed to the commissioner under this section is
101 true and accurate.

102 Sec. 6. (NEW) (*Effective January 1, 2018*) Not later than March 1, 2019,

103 and annually thereafter, each manufacturer shall submit to the
104 commissioner, in a form prescribed by the commissioner, a report
105 disclosing the value of all price concessions the manufacturer provided
106 to each pharmacy benefits manager for each prescription drug
107 administered by such manager during the previous calendar year. The
108 total shall be expressed as a percentage of the wholesale acquisition
109 cost for the drug. The manufacturer shall certify that that the
110 information it has disclosed to the commissioner in the report is true
111 and accurate.

112 Sec. 7. (NEW) (*Effective January 1, 2018*) Not later than March 1, 2019,
113 and annually thereafter, the commissioner shall submit a report to the
114 joint standing committee of the General Assembly having cognizance
115 of matters relating to insurance, in accordance with the provisions of
116 section 11-4a of the general statutes, concerning trends in the cost of
117 prescription drugs sold or distributed in this state. The report shall
118 include, but need not be limited to, information manufacturers have
119 disclosed to the commissioner under sections 5 and 6 of this act.

120 Sec. 8. (NEW) (*Effective January 1, 2018*) The commissioner may
121 adopt regulations, in accordance with chapter 54 of the general
122 statutes, to implement the provisions of sections 1 to 7, inclusive, of
123 this act.

124 Sec. 9. (*Effective from passage*) (a) There is established a task force to
125 study value-based pricing of prescription drugs. Such study shall
126 include, but need not be limited to: (1) An analysis of the information
127 disclosed to the commissioner under sections 5 and 6 of this act; (2)
128 recommended criteria for use by state agencies in determining whether
129 the cost of a prescription drug is reasonable; and (3) recommended
130 legislation or regulations to reduce the cost of any unreasonably costly
131 prescription drug.

132 (b) The task force shall consist of the following members:

133 (1) Two appointed by the speaker of the House of Representatives,
134 who shall have expertise in health care;

135 (2) Two appointed by the president pro tempore of the Senate, who
136 shall have expertise in consumer protection;

137 (3) One appointed by the majority leader of the House of
138 Representatives, who shall be a physician licensed under chapter 370
139 of the general statutes;

140 (4) One appointed by the majority leader of the Senate, who shall
141 have expertise in employment policy;

142 (5) One appointed by the minority leader of the House of
143 Representatives, who shall have expertise concerning the
144 pharmaceutical industry;

145 (6) One appointed by the minority leader of the Senate, who shall be
146 a pharmacist licensed pursuant to chapter 400j of the general statutes;

147 (7) Two appointed by the Governor, who shall have expertise in the
148 insurance industry;

149 (8) The Commissioner of Social Services, or the commissioner's
150 designee;

151 (9) The Insurance Commissioner, or the commissioner's designee;
152 and

153 (10) The Comptroller, or the Comptroller's designee.

154 (c) Any member of the task force appointed under subdivision (1),
155 (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member
156 of the General Assembly.

157 (d) All appointments to the task force shall be made not later than
158 thirty days after the effective date of this section. Any vacancy shall be
159 filled by the appointing authority.

160 (e) The speaker of the House of Representatives and the president
161 pro tempore of the Senate shall select the chairpersons of the task force
162 from among the members of the task force. Such chairpersons shall

163 schedule the first meeting of the task force, which shall be held not
164 later than sixty days after the effective date of this section.

165 (f) The administrative staff of the joint standing committee of the
166 General Assembly having cognizance of matters relating to insurance
167 shall serve as administrative staff of the task force.

168 (g) Not later than February 1, 2018, the task force shall submit a
169 report on its findings and recommendations to the joint standing
170 committee of the General Assembly having cognizance of matters
171 relating to insurance, in accordance with the provisions of section 11-
172 4a of the general statutes. The task force shall terminate on the date
173 that it submits such report or February 1, 2018, whichever is later.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2018</i>	New section
Sec. 2	<i>January 1, 2018</i>	New section
Sec. 3	<i>January 1, 2018</i>	New section
Sec. 4	<i>January 1, 2018</i>	New section
Sec. 5	<i>January 1, 2018</i>	New section
Sec. 6	<i>January 1, 2018</i>	New section
Sec. 7	<i>January 1, 2018</i>	New section
Sec. 8	<i>January 1, 2018</i>	New section
Sec. 9	<i>from passage</i>	New section

INS *House Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 18 \$	FY 19 \$
Insurance Dept.	IF - Cost	130,000	130,000
Various State Agencies	Various - Potential Cost	Less than 1,000	None

Note: Various=Various; IF=Insurance Fund

Municipal Impact:

Municipalities	Effect	FY 18 \$	FY 19 \$
Various Municipalities	STATE MANDATE - Potential Cost	See Below	See Below

Explanation

The bill may result in a cost to fully-insured municipal plans which impose a percentage based coinsurance or deductibles for prescriptions. To the extent the carriers base the percentage on the gross drug cost as opposed to the net cost, as required in section 3 of the bill, the municipality may be responsible for any difference between what is negotiated with the pharmacy benefit manager (PBM) and the cost-sharing required by plan members. There is no impact to the state employee and retiree health plan as the state plan does not have percentage based cost sharing for prescription drugs.

Section 4 of the bill is not anticipated to have an impact on the state employee and retiree health plan and fully-insured municipal health plans. One of the state plan carriers already complies with the terms of the bill. It is uncertain at this time if the other carrier has an

unbundled reimbursement structure. To the extent unbundling payments for physician administered prescriptions allows carriers (e.g. the state for the state plan) to negotiate directly on the reimbursement rates for physician administered drugs, which are currently paid for through the medical plan and not the prescription plan, there may be an impact.

Pursuant to federal law, self-insured plans are exempt from state health mandates.¹

Sections 5-8 of the bill result in an annual cost of approximately \$130,000 to the Department of Insurance (DOI). The bill requires prescription drug manufacturers to report to the DOI commissioner if drug costs exceed a certain limit and to submit an annual report on price concessions provided to the PBMs. It also requires the DOI commissioner to submit an annual report to the General Assembly regarding trends in the cost of prescription drugs sold or distributed in the state and to adopt regulations to implement the provisions of the bill. DOI does not currently have this expertise on staff and would have to hire an outside consultant to meet the requirements of this bill. As the requirements of the bill are on-going, it is anticipated that DOI will retain the services of a consultant at an annual cost of approximately \$130,000.

Lastly, section 9 of the bill establishes a task force to study value-based prescription drug pricing, which may result in a cost of less than \$1,000 in FY 18 to those agencies participating in the task force to reimburse legislators and agency staff for mileage expenses, currently at 53.5 cents/mile.

The Out Years

The annualized ongoing fiscal impact identified above would

¹ The state employee and retiree health plan is self-insured and therefore exempt from state health mandates. However, historically, the state health plan has adopted all mandated health benefits.

continue into the future subject to negotiated drug prices and consultant costs. There is no cost in the out years for the task force, which terminates in FY 18.

OLR Bill Analysis**sSB 925*****AN ACT CONCERNING THE COST OF PRESCRIPTION DRUGS
AND VALUE-BASED INSURANCE DESIGN.*****SUMMARY**

This bill imposes various requirements regarding prescription drugs on health carriers, group health insurance policies, health care provider contracts, drug and cosmetic manufacturers, and the insurance commissioner. Specifically, it requires the following:

1. Certain health carriers (e.g., insurers and HMOs) must offer health insurance policies that incorporate “value-based insurance design” (see below) (§ 2).
2. Certain group health insurance policies that cover prescription drugs and require an insured to pay a coinsurance or deductible must calculate such payment based on (a) the actual “net drug cost” of the drug (see below) or (b) an estimate of the net drug cost based on recent historical data (§ 3).
3. All contracts between health carriers and health care providers renewed, amended, or entered into on or after January 1, 2018 that cover the cost, administration, or overhead or handling of prescription drugs must separately reimburse the provider for the drug’s cost, administration, and overhead and handling. The bill prohibits these contracts from setting any of these reimbursements at a fixed percentage of the drug’s cost (§ 4).
4. Drug and cosmetic manufacturers (see BACKGROUND) must notify the insurance commissioner if they (a) sell or distribute a brand name or generic prescription drug with an initial annual aggregate “wholesale acquisition cost” (see below) of at least

\$30,000 or \$3,000, respectively, or (b) increase the aggregate wholesale acquisition cost of a drug sold or distributed in the state by more than 10% or \$10,000 for brand-name drugs and by more than 25% or \$300 for generic drugs (§ 5).

5. Drug and cosmetic manufacturers, beginning 2019, must annually submit to the insurance commissioner by March 1 a report on the value of all drug price concessions provided to pharmacy benefit managers (PBMs) for each prescription drug the PBM administered the previous calendar year. The total must be expressed as a percentage of the drug's wholesale acquisition cost, and the manufacturer must certify that the report is true and accurate (§ 6).
6. The insurance commissioner must report to the Insurance and Real Estate Committee by March 1, 2019, and annually afterwards, on the cost trends of prescription drugs sold or distributed in Connecticut. The report may include the information manufacturers disclose to the commissioner under the bill (§ 7).

The bill authorizes the insurance commissioner to adopt implementing regulations (§ 8). It also establishes a 13-member value-based design task force, which must study value-based pricing of prescription drugs and report to the Insurance and Real Estate Committee by February 1, 2018 (§ 9).

EFFECTIVE DATE: January 1, 2018, except the task force provisions are effective upon passage.

§ 2 — VALUE-BASED INSURANCE DESIGN IN HEALTH INSURANCE POLICIES

Under the bill, a health carrier must, for each policy it offers covering prescription drugs, offer a version of the policy incorporating "value-based insurance design," which the bill defines as any material term in a health insurance policy designed to increase the quality of covered benefits or health care services while reducing costs.

In developing value-based insurance design, health carriers must consider services and benefits that are (1) provided on an outpatient basis, (2) medically beneficial and cost-effective, (3) likely to prevent hospitalization or use of emergency services, (4) preventive, and (5) low risk for abuse or fraud.

These provisions apply to health carriers that deliver, issue, renew, amend, or continue a health insurance policy in Connecticut that covers (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) hospital or medical services, including those provided under an HMO plan; or (5) single ancillary services (e.g., prescription drugs).

§ 3 — COINSURANCE AND DEDUCTIBLES IN CERTAIN GROUP HEALTH INSURANCE POLICIES

Under the bill, certain group health insurance policies that cover prescription drugs and charge a coinsurance or deductible must calculate it based on the drug's actual "net drug cost" or an estimate of it based on historical data. The bill defines "net drug cost" as the cost of a brand name prescription drug or generic drug, including all discounts and rebates.

These provisions apply to group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

§ 5 — WHOLESALE ACQUISITION COST NOTIFICATION REQUIREMENTS

Drug and cosmetic manufacturers must notify the commissioner in writing when they (1) sell or distribute a drug in Connecticut that meets or exceeds an initial annual aggregate "wholesale acquisition cost" of \$30,000 for brand name drugs or \$3,000 for generics or (2) increase the annual aggregate wholesale acquisition cost by more than 10% or \$10,000 for brand name drugs or by more than 25% or \$300 for generics. Under the bill, "wholesale acquisition cost" is the cost of a

drug as listed in the most recent edition of the manufacturer's price list or catalog provided to wholesalers or distributors, excluding any discounts, rebates, or other price reductions.

Under the bill, manufacturers must send the notice to the commissioner within 60 days after the prescription drug's release or price increase, as applicable. The notice must be on a form prescribed by the commissioner and include:

1. a description of each factor the manufacturer used to calculate the drug's wholesale acquisition cost, including the percentage of the total cost attributed to it and an explanation of the role it played in the calculation;
2. a description of the manufacturer's efforts to reduce the drug's cost to consumers;
3. any increases in the drug's wholesale acquisition cost during the last five years;
4. the manufacturer's certification that the notice's information is true and accurate; and
5. any other information the commissioner may require.

§ 9 — VALUE-BASED PRICING TASK FORCE

The bill establishes a 13-member task force to study prescription drug value-based pricing. The study must include:

1. an analysis of the pricing information disclosed to the commissioner by manufacturers under the bill's provisions,
2. recommended criteria for use by state agencies to determine the reasonableness of a prescription drug's cost, and
3. recommended legislation or regulations to reduce unreasonable costs of prescription drugs. The task force must submit its findings to the committee by February 1, 2018, at which point it

terminates.

Under the bill, the task force consists of the following members:

1. two who have healthcare expertise, appointed by the House speaker;
2. two who have consumer protection expertise, appointed by the Senate president pro tempore;
3. one licensed physician, appointed by the House majority leader;
4. one employment policy expert, appointed by the Senate majority leader;
5. one pharmaceutical industry expert, appointed by the House minority leader;
6. one licensed pharmacist, appointed by the Senate minority leader;
7. two insurance industry experts, appointed by the Governor;
8. the social services and insurance commissioners, or their designees; and
9. the comptroller, or his designee.

The bill allows the House or Senate leaders, as applicable, to appoint General Assembly members to the task force.

The House speaker and the Senate president pro tempore must elect the task force's chairpersons from among its members. The chairpersons must schedule the first meeting within 60 days of the bill's effective date.

The bill requires the Insurance and Real Estate Committee's administrative staff to serve as the task force's administrative staff.

BACKGROUND

Definition of Manufacturer

By law, “manufacturer” is a

1. person who directly or indirectly produces, prepares, cultivates, grows, propagates, compounds, converts or processes, by extraction from substances of natural origin or by means of chemical synthesis or by the two, any drug, device, or cosmetic for sale;
2. person who packages, repackages, labels, or relabels a container under the manufacturer's own or any other trademark or label any drug, device, or cosmetic for sale; or
3. sterile compounding pharmacy that dispenses pharmaceuticals without a prescription or a patient-specific medical order (CGS § 21a-70).

Split Committee (Pursuant to Joint Rule 5(c))

The Senate Insurance and Real Estate Committee defeated a motion for a favorable report on the same bill by a 3-1 vote.

Related Federal Law

Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

COMMITTEE ACTION

Insurance and Real Estate Committee

House Favorable Substitute

Yea 9 Nay 8 3/15/2017